TRICARE Consumer Watch

Region 10 ◆ Quarter 1 CY 2004

HEALTH PROGRAM ANALYSIS & EVALUATION DIRECTORATE

Region 10: Sample size-822 Response rate-31.1% **MHS: Sample size-50,000 Response rate-26.6%**

Inside Consumer Watch

TRICARE Consumer Watch is a brief summary of what TRICARE Prime enrollees in your region say about their healthcare. Data are taken from the Health Care Survey of DoD Beneficiaries (HCSDB). The HCSDB includes questions from the Consumer Assessment of Health Plans Survey (CAHPS). Every quarter, a representative sample of TRICARE beneficiaries are asked about their care in the last 12 months and the results are adjusted for age and health status and reported in this publication. In 2004, a new version of CAHPS (3.0) is used. Some new questions cannot be compared with the old ones.

Scores are compared with averages taken from the 2003 National CAHPS Benchmarking Database (NCBD), which contains results from surveys given to beneficiaries by civilian health plans.

Health Care

Prime enrollees were asked to rate their healthcare from 0 to 10, where 0 is worst and 10 is best.

Figure 1: Health Care Rating

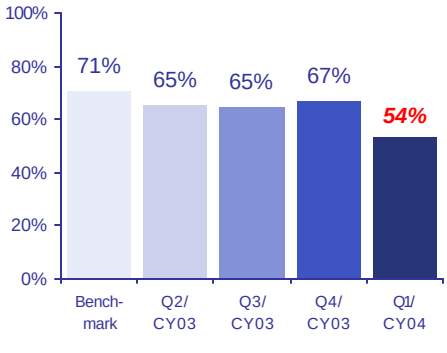
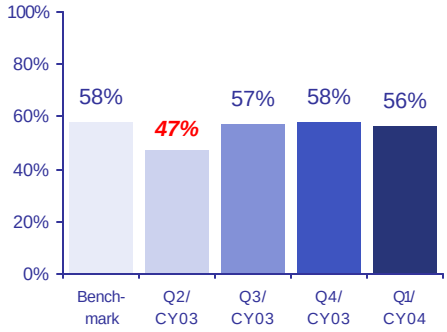


Figure 1 shows the percentage who rated their healthcare 8 or above in the survey fielded in the 1st quarter of 2004, describing the period October 2002 to September 2003, and each of the 3 previous quarters. Numbers in red italics are significantly different from the benchmark (p<.05). Health care ratings depend on things like access to care, and how patients get along with the doctors, nurses, and other care providers who treat them.

Health Plan

Prime enrollees were asked to rate their health plan from 0 to 10, where 0 is worst and 10 is best. Figure 2 shows the percentage who rated their plan 8 or above for each reporting period.

Figure 2: Health Plan Rating



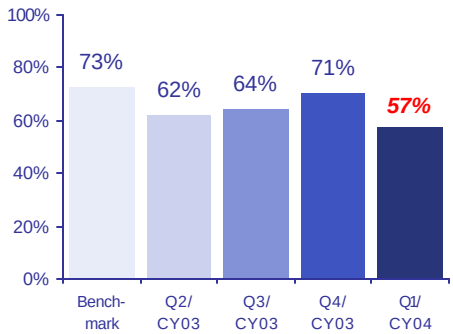
Health plan ratings depend on access to care and how the plan handles things like claims, referrals and customer complaints.

Personal Provider

Prime enrollees who have a personal provider were asked to rate their personal provider from 0 to 10, where 0 is worst and 10 is best.

Figure 3 shows the percentage who rated their doctor 8 or above for each reporting period. Personal doctor ratings depend on how the patient gets along with the one doctor responsible for their basic care.

Figure 3: Personal Provider Rating

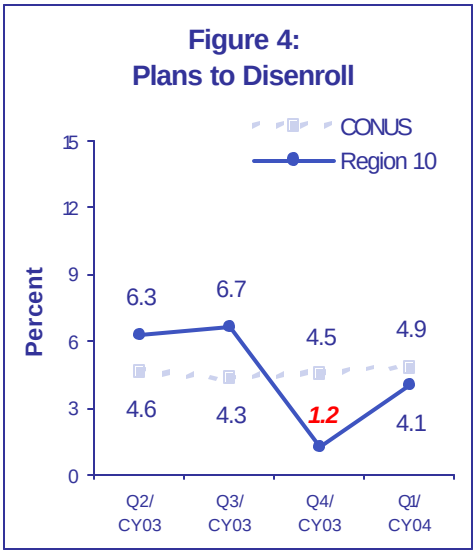


Plans to Disenroll

Enrollees were asked whether they plan to disenroll from Prime. Figure 4 shows the percentage of retirees and family members of active duty or retirees who plan to disenroll. Regional values differing significantly from CONUS (p < .05) are shown by red italics.

These groups have the option to disenroll if they choose, so their planned disenrollment rate is an overall measure of satisfaction with Prime.

Figure 4: Plans to Disenroll



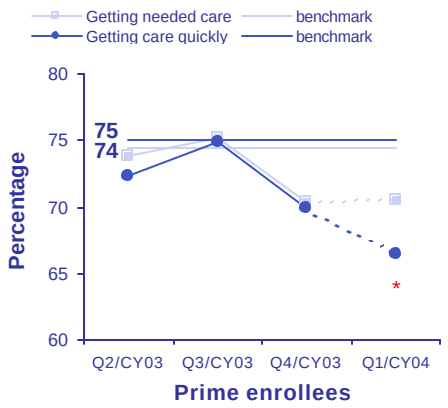
Health Care Topics

Health Care Topics scores average together results for related questions. Each score represents the percentage who "usually" or "always" got treatment they wanted or had "no problem" getting a desired service. Asterisks show values significantly different from the NCBD benchmark ($p < .05$). Hatched lines show where CAHPS 3.0 scores cannot be compared to CAHPS 2.0.

Figure 5 (Access Composites) includes the composites "Getting needed care" and "Getting care quickly."

Scores in "Getting needed care" are based on patients' problems getting referrals and approvals and finding a good doctor.

Figure 5: Access Composites



"Getting care quickly" scores concern how long patients wait for an appointment or wait in the doctor's office.

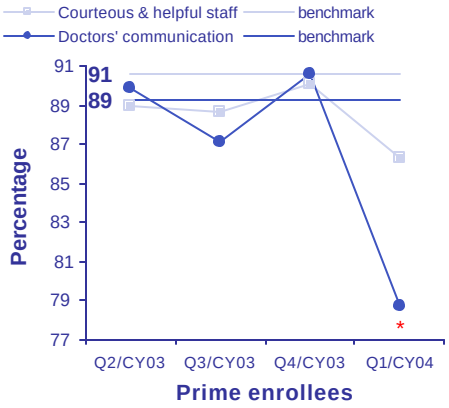
Figure 6 (Office Composites) includes the composites "Courteous and helpful office staff" and "How well doctors communicate."

Scores in "How well doctors communicate" are based on whether the doctor spends enough time with patients, treats them respectfully and answers their questions. "Courteous and helpful staff" scores measure both the courtesy and helpfulness of doctor's office staff.

Figure 7 (Claims/Service Composites) includes composite scores for "Customer service" and "Claims processing."

Scores in the "Customer service" composite concern patients' ability to get information from phone lines and written materials, and the manageability of the health plan's paperwork. "Claims processing" scores are based on both the timeliness and correctness of plan's claims handling.

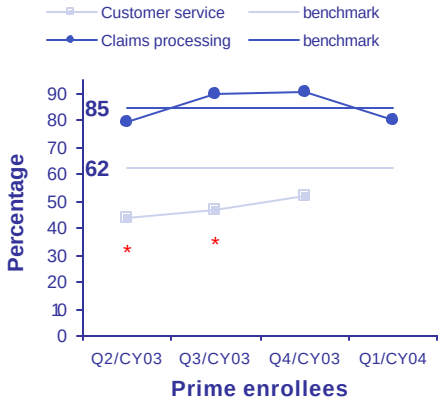
Figure 6: Office Composites



Preventive Care

The preventive care table compares Prime enrollees' rates for several types of preventive care with goals from Health People 2010, a government initiative to improve Americans' health by preventing illness. The table shows the most recent four quarters of data for five measures of preventive care.

Figure 7: Claims/Service Composites



Mammography is the proportion of women over age 40 who received a mammogram in the past two years. Pap smear is the proportion of women over 18 who received a Pap smear for cervical cancer screening in the past three years. Hypertension indicates the proportion of all beneficiaries whose blood pressure was checked in the past two years and who know whether their blood pressure is too high. Prenatal care shows the proportion of women pregnant in the past 12 months who received prenatal care in the first trimester. Cholesterol screen is the proportion of all adults whose cholesterol was tested in the previous 5 years.

Rates that are significantly different ($p < .05$) from the Healthy People 2010 goal are shown by red italics.

Preventive Care

Type of Care	Qtr 2 CY 2003	Qtr 3 CY 2003	Qtr 4 CY 2003	Qtr 1 CY 2004	Healthy People 2010 Goal
Mammography (women ≥ 40)	*94*	.	.	. .	70
Pap Smear (women ≥ 18)	92	87	96	92 (62)	90
Hypertension Screen (adults)	89	89	*87*	*86* (110)	95
Prenatal Care (in 1st trimester)	.	.	.	. .	90
Cholesterol Screen (adults)	*76*	*70*	*83*	*82* (109)	90

Issue Brief: Smoking and Smoking Cessation Policies

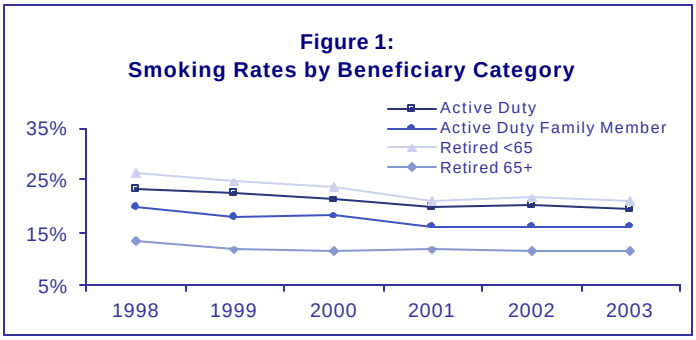
Each quarter, we publish a brief discussion, or issue brief, of a health policy issue relevant to users of TRICARE, based on data from the Health Care Survey of DoD Beneficiaries. This quarter, the issue brief concerns smoking and smoking cessation.

The armed forces have long had a reputation as an environment in which tobacco use is accepted and common[1]. Cigarettes were included as part of the K-rations and C-rations provided to the military during World War II[2]. Drill instructors and company commanders used smoking breaks as both reward and punishment. Early studies found that rates of tobacco use among the military were higher than those of civilians. However, beginning in the 1970s, the Department of Defense (DoD) changed its policies to discourage tobacco use and smoking rates have since declined substantially.

The DoD took its first major step to reduce smoking by discontinuing cigarettes in K-rations and C-rations to soldiers and sailors in 1975[3]. Then in 1986, a new health promotion policy prevented promotional activities by tobacco companies aimed primarily at DoD personnel; established a system to monitor use of tobacco products in DoD facilities; initiated smoking prevention and cessation programs; and proposed establishment of a Health Promotion Coordinating Committee[4]. That same year, tobacco use during boot camp was banned[3]. In 1996, tobacco prices in military commissaries were increased, resulting in a one-year tobacco sales drop of 20 percent[5]. In 1997, an executive order banned smoking, effective in 1998, in all interior space owned, rented or leased by the executive branch[6], except, temporarily, for certain Morale, Welfare, and Recreation (MWR) facilities. By December 2002, all DoD facilities were mandated smoke free.

In 1999, the DoD established the Alcohol Abuse and Tobacco Use Reduction Committee (AATURC). The Committee developed a strategic plan with the goals of reducing the smoking rate, promoting a tobacco-free lifestyle, educating commanders on how to encourage healthy lifestyles, and reduce access to tobacco[7]. Since its creation, the Committee has supported policies to bring tobacco prices at commissaries within 5 percent of local prices, helped to implement MWR smoke-free policies, and coordinated with the American Legacy Foundation to develop a DoD anti-tobacco marketing program[8].

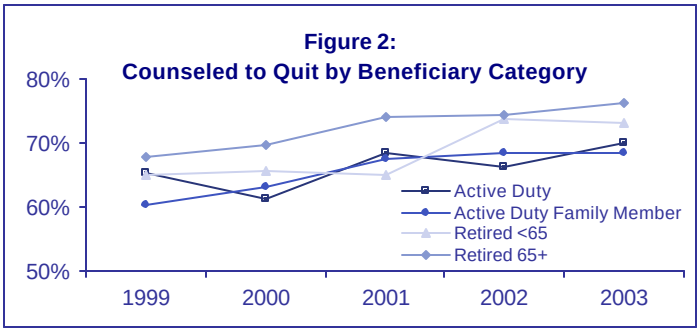
Figure 1:
Smoking Rates by Beneficiary Category



Besides barriers and price increases to reduce tobacco use, the military health system (MHS) offers assistance in quitting. Tobacco cessation programs and medications are available from MTFs of all services, though medication availability depends on the MTF's budget. In 2001, the MHS established a clinical practice guideline for cessation in the primary care setting. The guideline assists providers in detecting symptoms, assessing treatment readiness, determining the appropriate setting and intensity of treatment, and delivering individualized interventions[9].

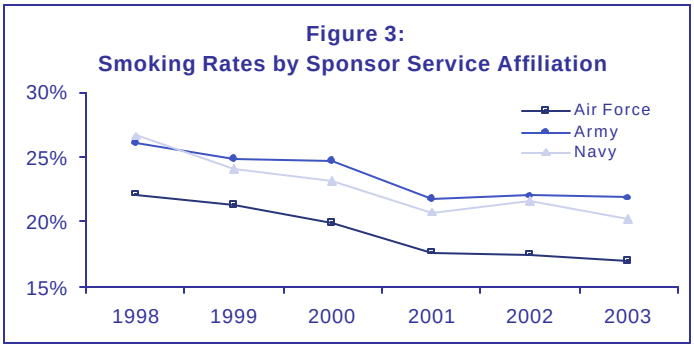
Figure 1 shows smoking rates calculated from the HCSDB for each beneficiary category, standardized by age and sex to the characteristics of that beneficiary category for 2003. Smoking rates for all groups declined between 1998 and 2003. The active duty rate fell from 24 percent to 19 percent and the rate for family members of active duty fell a similar amount, from 20 to 16 percent. Most of the measured drop in smoking rates occurred between 1998 and 2001, as rates changed little between 2001 and 2003.

Figure 2:
Counseled to Quit by Beneficiary Category



As shown in Figure 2, the proportion of smokers who were counseled to quit increased for each beneficiary group. That increase was smallest for active duty, whose rate went from 65 to 70 percent.

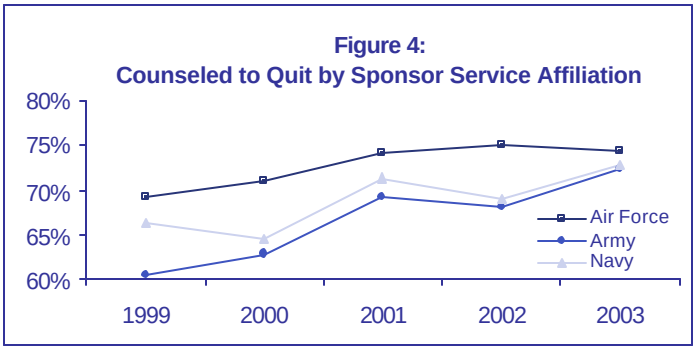
Figure 3:
Smoking Rates by Sponsor Service Affiliation



Each branch of service provides resources to encourage cessation. Each service offers similar provider training courses, for example, on prescribing nicotine replacement therapy medication and encouraging cessation. The Army

and Navy offer links to smoking cessation resources on wellness-promotion websites. For example, the Health Promotion and Wellness Directorate of the US Army Center for Health Promotion and Preventive Medicine and the Navy's Environmental Health Center provide websites with resources for both clinicians and patients.

Figure 3 shows smoking rates by service affiliation of the beneficiary's sponsor. These rates are age-sex standardized to be comparable between services. All smoking rates have fallen, with the largest apparent drop experienced by the Navy. Navy rates fell from 27 percent to 20 percent. The Air Force rate was lowest of the services in each year, falling from 22 percent to 17 percent. Figure 4 shows how many have been counseled to quit by service.



Counseling rates have increased for all three services, but differences between the services appear to have narrowed over time. Air Force counseling rates were highest in each year from 1999 to 2003, but the spread between the highest and lowest rate decreased from 9 percent to 2 percent.

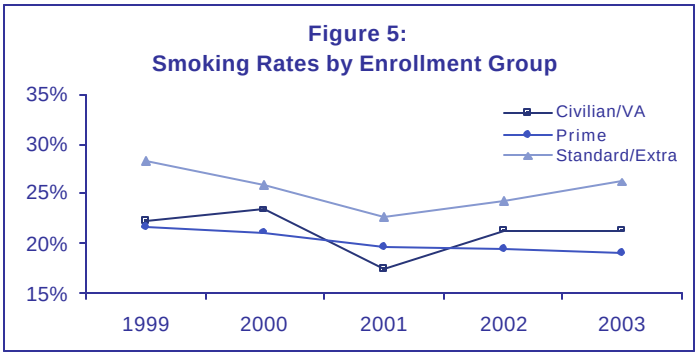
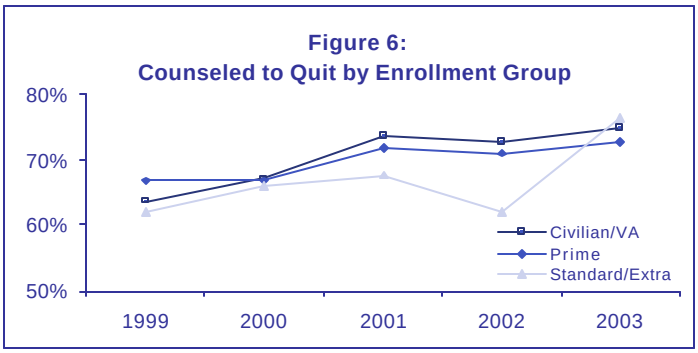


Figure 5 shows that age-sex adjusted smoking rates were highest for Standard/Extra users compared to other enrollment groups between 1999 and 2003. As shown by Figure 6, counseling rates have increased for all enrollment groups. Counseling rates were lowest for Standard/Extra users compared to Prime users and users of civilian insurance before 2003, when the rate jumped from 62 to 76 percent.

Although tobacco cessation programs and medications are available at MTFs, TRICARE policy specifically excludes reimbursement for cessation-related expenses[10]. However,



the AATURC has encouraged TRICARE to add a cessation benefit. In 2003, TRICARE proposed a demonstration program for such a benefit, to be piloted in a limited area in 2004 or 2005, and covering counseling and prescription and over-the-counter medications with preauthorization[10].

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